



## Views From Around A Crowded Bedside

**By GAIL SAIGER**  
PERIOD 1 is a rites-of-passage experience/ordeal at U. of T. medical school. Few people find it easy to maintain perspective and enthusiasm through the intimidation and anonymity of large lectures, unwieldy seminars, and dreary computer-marked multiple-choice evaluations of one's worth as a medical person.

It is with a sense of excitement, though, that most people greet Period II. Contact with patients; the opportunity to apply the minutiae we have learned to real, live, perhaps desperate people; the small clinic group system of interaction and learning—all provide an incentive to absorb and create, that the interpersonal vacuum of Period I cannot offer.

In Period I we watched with annoyance and a sense of impotence as "seminars" grew from twelve people to thirty or forty, turning with rare exception into further didactic sessions. We were led to expect that the staff-student ratio would be much more conducive to learning in Period II, as we are taught to treat patients as people instead of as examples, and much more conducive to developing relationships with teachers on an ongoing, intimate basis.

But the annoyances of Period I have turned to gloom and anger in Period II as clinic groups, sometimes by design and sometimes by accident, grow from an uncomfortable six people to a staggering seven, nine, and on occasion twelve bodies huddled around a startled patient. And the sense of impotence persists.

Having been organized into the "traditional" groups of six for clinic groups, the class of 7T6 was

startled and upset to find that the groups at Toronto General Hospital have been increased to seven members each.

But the problem is not unique to TGH. In the past many hospitals have had to increase the size of clinic groups in isolated systems when not enough clinicians could be found.

## MED SCHOOL

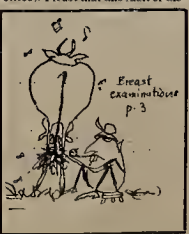
By PAUL T. RANDALL, MD, TT2  
**JUST** how did my undergraduate training at the University of Toronto medical school prepare me for general practice in a small town setting? It did and it didn't.

Faculty policy makes no promises to prepare you for general practice, but "to fashion a climate of learning which will . . . endow the student with . . . knowledge, skills . . . basic to the furtherance of any career in medicine" (—from the Calendar). One must always remember that the kind of internship taken, perhaps one's elective experience, and finally any postgraduate training have a huge amount to do with one's preparedness for family practice.

Nonetheless, there are a few things that stand out in my memory of undergraduate education - preponderance of teachers who are specialists and super-specialists. Some of these distinguished academicians had an open disdain for general practitioners and one remembers seething denunciations of the treatment afforded a certain patient at the "Elsewhere General". Surely, such attitudes are hardly encouraging to

What is distressing is the ease with which we get used to these injustices, the appalling lack of communication between the "powers-that-be" and the students, and the fact that, despite the unhappiness and the unwieldy size of clinic groups, the school is soon said to be expanding its classes from 250 to 320 souls.

## A GP Looks



Although the numbers game with clinic groups seem to be played arbitrarily and unilaterally (i.e. the students are neither consulted nor even forewarned), it is not only the students but the clinicians as well who are dissatisfied.

As evidenced at a recent Period II committee meeting, systems

In terms of the undergraduate curriculum itself, there are a few comments I have to make. I realize that the curriculum is crammed, and always will be, but in the context of a potential family doctor, there are a few things

For example, in Period II we spent an entire hour on hereditary fructose intolerance. But obesity is the commonest metabolic disorder, and its management is surely perplexing. Let's put some emphasis on things as they are in the real world. I learned a lot about subaortic muscular stenosis, but not much on the evaluation of innocent heart murmurs in children and adolescents and which ones to refer to the specialist.

The whole topic of allergy may be an unacceptable one to ivory-tower clinicians but it's a fact of life in general practice. I heard virtually nothing about testing and desensitization and allergic management in medical school.

Simple things, such as what constitutes basic sound prenatal care, how to insert an IUD, and

(see GP, page 4)

chairmen and clinicians in general are frustrated by the increasing number of students which each is being required to accommodate. As the size of groups grows (and who will assure us that it stops at seven?), discontent and effort increase, while the returns become more and more feeble. It is no wonder that staff and student alike are finding it easy to get turned off.

If opinion about the disadvantages of increasing clinic group size is so widespread, then who is making the decision to expand? Counting up the number of hospitals in the Toronto area, the size of the medical faculty, and the capacity of the medical building itself, it may appear that the resources of the faculty are flexible beyond the present size

But the peripheral non-teaching hospitals are only beginning to be organized into the teaching scheme, clinicians are overloaded at present and becoming more so, and students who are trying to learn clinical skills for the first time are feeling frustrated and neglected.

Before a full-scale expansion takes place, we must have some reassurances that it will not be at the sacrifice of the quality of our medical education. Make-shift readjustments year by year as the school gradually enlarges are frustrating and confusing to all concerned, and cannot help but influence the quality of education.

Until the peripheral hospitals can be properly integrated and a reasonable uniformity assured, until more clinical staff can be persuaded to teach undergraduate medical students, the resources that the Faculty shows on paper

(see Clinicians, page 12)

# Multiple Choice

WHICH of the following statements is most nearly correct?

- Ontario needs more physicians.
- Ontario has too many physicians.
- Ontario needs more clinician-scientists.
- None of the above.
- All of the above.

These are confusing times. The Globe and Mail in a Feb. 15 headline announced, "Quotas May Be Set To Avoid MD Surplus". The Globe went on to say that the provincial health ministers meeting in Ottawa suggested "they would consider restrictions on enrolments in medical school".

And yet just two years ago the report of the Task Force on Future Arrangements for Health Education (the Mustard Report) urged substantial increases in enrolment in Ontario medical schools as one component of the solution to the physician shortage.

The Long-range Planning and Assessment Committee of the faculty struggled with the Mustard and other reports on medical manpower in 1972 and 73 and finally recommended that enrolment of the first year

undergraduate medical students increase by 100, staged over a three-year period.

This recommendation seems rather ambitious in the light of the shortage of qualified, interested clinicians for bedside teaching (see Views, page 1).

How can the faculty hope to expand, when it cannot effectively teach the students it already has?

Faculty might have another problem on its hands. The health ministers are likely "To ensure that the specialization adopted by medical students corresponds to the needs of the community" (Globe and Mail—in other words, demand more G.P.'s in the northern communities).



U. of T. has not done well in generating physicians for medically underserved areas of the province.

The Ontario Medical Review (Dec. '73) reports 23 U. of T. graduates in the government's program to provide medical

services to rural and remote communities. Queens, with about 1/4 of Toronto's medical student enrolment, has only 22.

Perhaps U. of T. does not equip its graduates with enough confidence, or the right kind of capability, to practise medicine in a rural setting. Previous issues of Auricle have suggested that constant and exclusive exposure to super-specialist clinicians in academic teaching hospitals, does not produce well rounded physicians capable of practice outside the teaching hospital.

One possible remedy to this problem is presented by Dr. Morgan (see page 6).

However, if future medical school graduates opt for family practice, there might be a number of problems of a different sort.

Some members of the Ontario College of Family Practitioners feel the only way to prepare for general practice is via the 2 year Family Practice program, and that unrestricted licenses should be granted only upon completion of this minimal requirement (see Ticket to Ride, page 8, and Living With Licensure, page 9).

But these programs are available only in university teaching hospitals and are rapidly reaching maximum capacity.

Those of you that can see through the confusion should circle the appropriate

(See King Kong, Page 6)



Dr. Edward Llewellyn-Thomas is the new associate dean of medicine—student affairs. As an engineer/physician/teacher he has worked in pharmacology, electrical engineering, general practice and aerospace medicine (to name only a few). A benign rumble from the new dean is on the facing page.

# Lawrie's Assembly Line -- The Bast Physician

On February 20 groups of faculty and students met at the U.E.C. Think I'd discuss the philosophy and relative success of this Faculty in producing a blast (stem cell) physician. The following remarks are condensed from a student discussion paper co-authored by myself and Barry Tepperman after many discussions with our colleagues.

According to this concept the medical student, after his four-year experience as an undergraduate should be able to differentiate along any line in which medical personnel find themselves, i.e. he should be pluripotent. This implies that after graduation the previously uncommitted, undifferentiated physician could select from a basic science career, a medical or surgical specialty, a career in family and community medicine, preventive medicine and public health, a diagnostic specialty such as radiology, laboratory medicine and pathology or administration. Without judging the efficacy of this concept, let us briefly review the alternatives.

It is logically possible to allow the student to differentiate earlier in his career. This conceivably could be done from the first day of medical school as has been attempted at the University of Calgary. It was the objective of

the Calgary group to prepare their students for primary care or general practice. However, after the graduation of their first class in the spring of 1973, 29 of 34 students had opted in favour of something other specialty.

Another solution is to allow students the option of selecting a general area of interest at some time during their undergraduate days. The faculty at McGill has implemented a program whereby second year students would select optional subjects comprising 30 per cent of their program. The optional areas would be in family practice, medical specialty, surgical specialty and psychiatry.

This optional experience would be combined with a common core of compulsory courses comprising 50 per cent plus elective time of 20 per cent. Perhaps the most extreme model would be to allow the student relative freedom to select the courses consistent with his particular goals and insist only that he pass his final or qualifying examinations. This concept is naturally loaded with many problems.

After thinking about this blast concept we felt that our graduate class was severely restricted and handicapped if he chose to differentiate along certain lines. We felt that there were certain areas of our curriculum that were

absolutely deficient, others that were relatively deficient and still others where the material was redundant or poorly placed.

Regarding areas of absolute deficiency, it was felt that students who chose these areas would be handicapped unless they were extremely talented or they had prepared themselves for this area by diligent use of elective time and summer employment. In other words, these students would only fit logically into the program if they were gifted or had already become committed to a discipline earlier in their career. The areas of absolute deficiency, in our opinion, were pathology, pharmacology and therapeutics, preventive medicine, forensic medicine and medical-legal aspects of medicine, and unfortunately, family and community medicine.

The areas of relative deficiency were somewhat more difficult to define but we felt that our background in the Behavioural Sciences was somewhat inadequate partially because it appears so early in the program and must compete with several demanding courses and partly because it lacks relevance or credit to the student when placed with the basic sciences.

On reviewing the format of the Toronto curriculum, we felt that the separation of clinical and basic sciences into two well-defined eighteen-month time periods was artificial. Although this division seems somewhat logical for those students choosing a clinical specialty it tends to disadvantage students aspiring for careers in the basic sciences. We felt that there was a definite place for anatomy and histology and other basic science teaching in the clinical years.

Although we had reservations regarding teaching of all clinical and basic science material constituting a given discipline at one time, we felt that it did offer some advantages. The overlapping of material in biochemistry, cell biology, and immunology, pathology and

infections suggested a possible streaming or consolidation of these areas.

The relative absence of family practice experience from our curriculum we felt was an acute problem. It was surmised that the undergraduate gets adequate and perhaps excessive exposure to most specialties, but his knowledge of family practice is based largely on his experience as a patient. We concluded that if we are to produce a "blast" physician, then he must have more knowledge about the role of the primary care physician.

In conclusion we felt that the concept of a "blast" physician offered certain advantages to the student. It should give him adequate exposure to all areas of medicine and would facilitate his career choice. We do not know at what point the differentiation process should begin, however, we felt that it should not occur before the clerkship.

It was felt that for those

students who make a career choice earlier, diligent use of elective time and summer employment are perhaps the best opportunity to facilitate earlier differentiation.

Regarding the efficacy of the present system we felt that there are many areas of inadequacy. The areas of absolute deficiency require urgent action, while many of the other problems cited could be remedied by restructuring and re-organizing the existing program. We do feel that earlier differentiation or streaming is a viable alternative provided that the student has some opportunity to explore the various areas of medicine before deciding and that there is some mobility possible between the various streams.

We are aware that many interns are not sure of their future career plans and feel very strongly that the opportunity for late decisions regarding the field of practice should be part of any training program.

# Student Weekend

On the weekend of February 8, 9, & 10 the Medical Society hosted the fourth annual Medical Student Weekend. About 100 students attended from the other four Ontario medical schools plus one student from McGill. A program of activities ranging from social to athletic kept our visitors occupied. It was a stimulating experience to meet and compare views with our visitors.

In the discussion sessions on Saturday afternoon an exchange of views regarding curriculum of the various schools was quite a revelation. For example, did you know that the present first year class at UWO will begin their clerkship during their third year and in effect will choose elective or optional experience for most of their fourth year?

It is interesting to reflect on the respective characteristics that students from the various schools tend to portray.

The Ottawa students reminded me of the typical "Good-time-bros" type who would burst into song or have a beer with you at the drop of a hat.

The McMaster students were the "used car salesmen" of the group. They spoke convincingly and with polished poise about their educational experience. However the use of exemplaries and clichés in every sentence alerts the astute listener. In all honesty though, this group would be the first to admit they are indeed doing some scientific life kicking.

To my mind the Queen's and UWO students are somewhat similar. They represent the old guard, the school lie crowd, and portray some of the more traditional aspects of medical students.

It would be unfair to impose an image on the U of T students since we all know what the results would be. (See Profile, Page 9).

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Message: Ronald Cyr, Marshall Korenblum, Hazel Lawrie, Edward Llewellyn-Thomas, Robert Morgan, David McGivillay, James Miles, Robert Morgan, Michael Myskatin, Peter Petrosnick, Paul Randall, Gordon Reid, Warren Rubenstein, Gal Saiger, Louise Sims, Ken Sirén, Murray Treloar and Paula Williams.

Medium: David Cole, John Marshall, Harriet Train and Jean Weir

Fr. Mole, Petrosnick and Wills

Guiding Light: Ste. Molly of the Blessed Sacros.

Special Thanks: to the elves of Dorann

—Michael Wills, Editor



# Clinical Clerks Tell What It's Like -- Sunnybrook

By DAVID MCGILLIVRAY  
I REALIZE that by now the period IIC people have already chosen their clerkship hospitals for next year. This note is to let those clerks who are coming to Sunnybrook know what to expect and let the other period II people know a bit more about Sunnybrook.

Of the 48 weeks in the clerkship 20 weeks are actually spent at SBH if the clerk does his elective outside of the hospital (which is the case in most instances). I have now completed 23 of those weeks and therefore can tell you a bit about most of the rotations.

## Ambulatory Care

Three weeks of this rotation are spent in the family practice unit of the hospital where the clerk is assigned to two physicians. In most cases the clerk will see the regularly scheduled patient first and then talk the problem over with the physician who will then check the clerk's findings and then together a final treatment program is decided upon.

Often the staffmen will simply observe the clerk examine and take a history without interrupting so that he can later offer constructive criticism.

During this three-week period the clerk receives six and a half days of dermatology in which the clerk mainly participates as an observer in a dermatologist's regularly scheduled office.

Two weeks of this rotation are spent on E.N.T. Most of the time

is spent in the outpatient's clinic. There is a minimal amount of time spent in the O.R. and on the ward.

The stress in teaching has with teaching common problems with respect to the ear nose and throat. As well much time is spent teaching the clerk to do a proper E.N.T. examination. The clerk gets a lot of time to practice this.

There are daily one-hour seminars for the clerks (one staffman to two clerks). These are excellent.

Ophthalmology takes up another two-week period. Again most of the time is spent in the outpatient department with a minimal amount of time spent in the O.R. almost no time spent on the wards. Due to the specialized nature of the ophthalmological examination much of the work is done by the staffmen but the clerk gets lots of practice in important but simple procedures such as measuring ocular pressure etc. A great deal of teaching comes by way of readily available tape-slide presentations. Short seminars are also provided spontaneously by the staffmen.

In this rotation the clerk is assigned to a particular psychiatric ward (one clerk per ward) where he is assigned to be under the particular physician. On the ward the clerk is put in charge of his own patients and uses the resident as a consultant.

The clerk is given his own office for the month where he can

interview his patients in private. The clerk also spends some time doing emergency calls with the resident in the emergency department. The clerk also is expected to see consults from other areas of the hospital which will later be reviewed by the resident and staffmen.

Other clinics which the clerk may attend are the schizophrenic clinic, affective disorders clinic, and alcoholics clinic. There are 12 one-hour seminars given per month on major psychiatric topics (one staffman to two clerks). Grand rounds in psychiatry are held weekly.

Here the clerk chooses two of the following wards he would like to be on: Cardiology, Gastrointestinal, Rheumatology, Neurology, Respiratory, Renal, Endocrine and Metabolic, General Medicine, and Haematology.

It is recommended and probably mandatory for the clerk to choose at least one ward where he will encounter general medical problems. For example the combination of Neurology and Cardiology would not be desired as both these areas are quite specialized. Cardiology and Renal or General Medicine would be preferred.

Numerous seminars are available for the clerk while on the ward. Twice weekly the clerk meets with a staffman for bedside discussion of a case which is presented by one of the clerks on medicine (five clerks to one

staffman). The emphasis here is on the therapeutic aspects of the case.

Each Wednesday afternoon the clerks on medicine and surgery meet for one and a half hours for radiology sessions in which common radiological problems are discussed and the clerks get practice in reading X-rays.

While on medicine the clerk is required to be a member of a team and look after his own patients. The number of patients depends on the clerk.

Most of the teaching is done by the residents. The on-call schedule is about one in three or one in four. If the clerk wants to be on call more, the residents are only to happy to let you take calls for them.

## Surgery

Here the clerk chooses four out of five possible rotations. He will spend two weeks on each rotation. The rotations are Emergency, Neurosurgery, Urology, General Surgery, and Orthopedics. The program varies with each service. In most cases the clerk is assigned to one resident and staffman. The clerk is on call when his resident is on call. The schedule is variable.

The amount of time spent in the O.R. is up to the clerk. The stress

in teaching is not on the actual surgical technique but on diagnosis and good pre-op and post-op care. Individual wards have their own individual seminars which the clerk may be required to present at. There is not time here to cover all of the different services.

This "note" is already too long, to summarize Sunnybrook is an excellent clerkship hospital.

Like any other hospital the clerk is going to have to be a little more aggressive than he is used to. If he is going to get the maximum out of his clerkship. The residents and staff are very good about teaching and if you show you are interested you will find them looking for you whenever anything interesting is going on.

There is as much to do as the clerk wants to do, but the clerk has to keep his ears open if he wants to find out about things going on.

Additional thoughts include: noon hour seminars for all the house-staff eat your lunch while learning; duty rooms are adequate with lounge, television, pool table, and beer machine, and kitchen available; it costs \$65 a month to live in, there have been four parties this fall for nurses, interns, residents, clerks, and staffmen which were quite successful; and finally I have not covered the rotations done outside the hospital since these will be covered in discussions about the other hospitals.

## Letters To The Editor

To The Editor:

I have read the most recent issue of the Auricle and was particularly interested in the report of the clinical clerkships at Toronto General, Women's College and Wellesley Hospitals. I will see to it that the Chairmen of Clinical Departments will be made aware of this report and alert them to watch for subsequent articles in the series.

I think this type of "consumers' report" should provide a valuable component of any revision of the clerkship process and details of it.

Along the same line, I was also interested in reading Lawrie's Assembly Line. His comments regarding the students' exposure to the Department of Family and Community Medicine were also most interesting and will receive serious consideration.

Keep up the good work! R. Brian Holmes, M.D., Dean, Faculty of Medicine.

To The Editor:

1. Conceded: Taking a life is "murder." Aboard of a life takes "murder."

2. Death by deprivation is psychological slow "murder" over many years.

3. Permitting a mother to bleed to death after bringing on abortion could also be "murder" of the mother, adolescent, or unwed female.

4. Ideally life and death are status we don't really yet understand. Fully can't explain without some mystery and can't arrange to suit our convenience without consequence.

If Doctors, especially females, cared about the care of women—they would get together and fight the present "double" standards of our society that leaves all the burden of birth,

birth control, abortion, child-rearing, etc. for the humble female, who MUST suffer for her sins. We seem to forget it takes two people—male and female—to create even a fetus.

Why should the WOMAN be so strong as to take all the burden, mental and physical? Where is the man who creates the life as well? SOCIETY never questions, punishes, or burdens the Romeos of our era!

The doctors, social workers and welfare departments are burdened with trying to find

solutions to our antiquated SOCIAL RESTRICTIONS—as per Section A, B, C or D Regulations. Life isn't one neat little set of rules as per a program or a few puritans!

Let's ALL STOP BRING SUCH ANONYMOUS HYPOCRISIES TO THE PROXY TABLE STAND to help all living persons, for the Hippocratic Oath states—save "life" or "lives".

Decisions would be easier "pro life" if we didn't punish the girls and treat them as "killers." "Prostitutes do better—at least



they have MONEY to pay for best of services.

Our total attitude must change re our females! They are persons—who feel, too. They need love and care. They are weak, not always strong. They need friends. We alienate all mothers to day as sinners when they are VICTIMS of the FASSIONS of men — K. Aivait

## Bowel Sounds

By EDWARD LLEWELYN-THOMAS, M.D.  
WHEN I ARRIVED on the scaffold I was asked by your Editor for some inspiring words, so I prepared a fine borborygmus. My enjoyment, while listening to the subsonic release of my own hot air was tempered by ersorbic snickers and hostile groans from the ersorbic medical student who still lurks somewhere in my left frontal lobe and disapproves of academic platitudes.

One, however, that went by without evoking his scorn, was "Love one another." This terse imperative was not hedged by escape clauses such as "not physically," or "people you like," or "people who like you," or "people who are like you".

The student within did not jeer at this uncomfortable advice, as he did at my more sophisticated sentences—perhaps because the person he has become was greatly impressed by one aspect of the youth revolution a few years ago. They seemed to be the first generation in recent history to take this advice seriously. Judging from the visitors who turned up on my cheerfulness after having been offered food and shelter by my children (who of course squatted around at intervals by themselves roosting elsewhere when afraid in some other city) a generation was emerging which looked out for each other.

I hope medical students are not a fair sample of this generation, or my sentimental optimism is destroyed. Mutual support for faltering comrades is not among the most obvious of

their behavioral characteristics.

My brief exposure to academic first-aid confirms my fear that if an average group of medical students suddenly converted into a team of Arctic explorers they would rather freeze individually than survive together.

There has certainly been much pressure from outside to introduce ideas of social responsibility and relevance into the curriculum — as long as the responsibility is postponed for several years and is relevant to any group other than the one they are in at present. There are great waves of verbal sympathy, for unfortunate safety remote in far countries, but little warmth for the unfortunate at the next lab bench.

My alter ego is now jumping up and down in my left lateral ventricle gibbering "You can't vote for the sort of thing it's unfair, brutal and inhumane. Also it's not true."

OK. So show me it's not true.

Those of you who become real physicians with, for the rest of your lives, be concerned with the ready application of new knowledge to the welfare of your fellow human beings. In the process you will be supporting the distressed, the sick and the dying. So how about getting some practice in practical humanity on each other, even if none of you needs warm companionship and help with Topic/System/Subject xyz? After all you don't need to find somebody who is half dead before you practice resuscitation - mouth-to-mouth or cardiac.

## Topic Of Cancer

By WARREN RUBENSTEIN

IN THE past month, a group of students from several faculties on the University of Toronto campus have met inconspicuously to discuss possible involvement of Cancer Society students in activities of the Canadian Cancer Society.

After much debate, they decided to meet the cancer problem head on. "Considering the present state of the science of medicine," said the students, "the most important step in curing cancer is EARLY DIAGNOSIS." To this end, the group has decided to launch a campus information programme "to open eyes and reduce fear". They intend to design brochures and posters and to write articles for campus newspapers defining cancer in simple terms, outlining the present status of treatment and research and establishing a pattern for self-examination and diagnosis.

"We also want to get Health Science students involved in teaching the general public about cancer," the chairman said. Thus, the committee is presently investigating several possible areas for student-run public education. These could include high school science classes, the Cancer Society's Grade 10 anti-smoking campaign, an industrial educational program, and lectures to club groups and library meetings.

Finally, the committee hopes to locate those students on campus who have some spare time and an interest in social service and inform them about the Cancer Society's extensive service to patients' program, i.e. a patient's visiting and transportation, housekeeping, etc.)

Those interested in working on these projects should contact Warren Rubenstein at 661-2492.

G.P. (from page 1)

what to tell the mother of a newborn baby about breastfeeding seem to have been glossed over or omitted altogether in my undergraduate training. And these are bread-and-butter jobs in general not specialist practice.

Dermatology was a poor relation in the system/topics of my undergraduate years. Perhaps part of the problem was that most of its patients are ambulatory and most undergraduate teaching patients are not. This preoccupation with in-patients in the super-specialized downtown teaching hospital has its effects on the education of a potential family practitioner in many areas, not just dermatology.

I gather they're better represented in the curriculum now. Dermatological problems are common in family practice.

One area that I feel was not touched on very much was that of pharmacology/therapeutics: a critical evaluation of the products promoted by the pharmaceutical companies; the combination drugs for various symptomatic problems. One is deluged at nausium with information and samples. I believe we could benefit by a more critical approach to drugs in general.

Lastly, I feel that my knowledge of medicine and the law was woefully lacking. As an intern I was asked by a lawyer to witness the signing over of power of attorney by one of my patients to his son. I had no idea of the legal meaning of "power of attorney".

or of the implications of my involvement as a medical person at that instance. Similarly as a clerk, intern, or practitioner, the question of consent, the problem of rape, the Coroner's Act, the Public Health Act, to name a few, are all legal entities with which one must be familiar. Medical jurisprudence should be a good part of the Period II curriculum.

I realize that I have picked on certain aspects of the undergraduate curriculum to illustrate some of the deficiencies with which it leaves a future family doctor. No curriculum is perfect, nor can it be all things to all possible kinds of doctors. The gaps that I have discovered in my knowledge have stimulated me to think, to read, to go to refreshers, to get advice from other physicians: i.e. continuing education.

Certainly the best possible preparation for general practice lies in the Period II Principles and Methods of Diagnosis, for many of one's mistakes in practice result from failure to take a good history and to do a good physical examination. One can never get enough of that particular training.

I trust that this essay has been a constructive and reasonable critique of undergraduate education from the viewpoint of a new general practitioner. Without excusing the weaknesses and deficiencies in the curriculum or the abundance of "canaries" and specialist-oriented topics, the old adage also applies: you get out of it what you put into it.

**ST. MICHAEL'S COLLEGE**  
and the  
**FACULTY OF MEDICINE**  
PRESENT  
**A LECTURE SERIES**  
March 1974.  
"SCIENCE AND MEDICINE:  
THE MORAL DIMENSION"

- March 11 Dr. H. K. Beecher, Harvard University "Experimentation in man and the right to be alone."
- March 18 Prof. H. Krevier, Q.C., Faculty of Law, U.W.O. "Minors and the age of consent for medical treatment."
- March 28 Prof. J.M. Gustafson, B.D., Ph.D., U of Chicago. "Genetic Screening and Human Values."

**MEDICAL SCIENCE AUDITORIUM**  
**ADMISSION FREE 8:00 PM.**

**THE  
MEDS  
FORMAL**  
IS

Saturday  
March 23rd, 9 p.m.  
King Edward Sheraton  
Hotel Ballroom  
Two Bands.  
Open Bar - Drinks reasonable  
price  
\$6 per couple (students)  
\$8 per couple (staff)  
Tickets available at Meds  
Society Office



# WORDS, WORDS, WORDS

By HELEN EVANS REID, MD  
I KNOW YOU BELIEVE YOU UNDERSTAND  
WHAT YOU THINK I SAID, BUT I AM NOT  
SURE YOU REALIZE THAT WHAT YOU  
HEARD IS NOT WHAT I MEANT. ☹

Ordinarily ☹ stands for copyright. Here it stands for confusion: a confusion of words.

Communication is not confined to words alone. Today messages are transmitted in many ways: by lacking arms in communal baths; by gentle touch or murderous football impact; by lullaby or shrug; by tears; by music; by pictures. But these forms of communication are fleeting. The receiver will remember only the effect, long after the message is gone.

For science the message must be written or recorded, incoded or diagrammed, capable of being stored, recalled at will and understood exactly as intended, independent of infection, gesture or physical contact.

Why not try words? Plain words.

Why say:

"Pathologic processes, that through therapeutic negligence or unavailability of medical attention, have been permitted to progress to the point of endangering the existence of the patient, can be adequately coped with only through the application of heroic and inherently hazardous measures; in the application of such measures only a fatal termination can be anticipated."

An understandable, but boring excess. Why not just say:

"Serious ailments often demand hazardous remedies."

But let not the words be vague words or vague words, chosen not to inform but to plug the holes in the author's thinking. Why say:

"Skills constitute the manipulative techniques of human goal attainment and control in relation to the physical world, so far as artifacts or machines especially designed as tools do not yet supplement them. Truly human skills are guided by organized and codified knowledge of both the things to be manipulated and the human capacities that are used to manipulate them. Such knowledge is an aspect of cultural-level symbolic processes, and ... requires the capacities of the human central nervous system, particularly the brain. This organic system is clearly essential to all of the symbolic processes; as we well know, the human brain is far superior to the brain of other species."

You made it this far? That's perseverance.

You now know the author was trying to say: "A developed brain and acquired skills and knowledge are necessary for attaining specifically human goals."

Some communicators cannot resist the itch to "live": the scholar who faldetrizes (faldetrizes is little worse than the business man who finalizes) concludes an agreement, the electrician who relectrifies a lamp can charge more that way or the physician who described a child as grossly undersized.

Scientific communication demands the same qualities as science itself: logic, clarity and precision. Those who deplore the standard arrangement of the scientific article into Introduction, Materials and Methods, Results and Discussion because the uniformity is tedious, or because the pattern suggests a logic that is nonexistent, should remember that no one authoritatively imposed this pattern. It evolved.

It evolved as the logical form for communicating scientific material.

Clarity and precision are the watchwords of

science.

"Surgery may be indicated for solitary nodules when they cannot be distinguished from a neoplasm or where the solitary nodule arises as the result of a blocked cavity particularly if they subsequently reopen to again form a cavity."

A rough idea of what the author meant is the most the reader can hope for. But a rough idea would be no authority for a deposition before a court.

If the logic, techniques, and measurements of science must be precise, then the words used to describe them must be equally precise. To communicate, even in the simplest language, requires a sensitivity to differences in the meaning of words; for example, the differences between amount and number, dose and dosage, prior and before, variable, various and varying, therapy and treatment, mitigate and mutilate, verbal and oral, comprise and constitute, method and methodology, extremities and limbs, and so forth.

The scientist must know the difference and he must care. If he doesn't his audience won't know what he means and they won't care either.

Effective communication in science depends also on style, that subtle compound of art and craft. The craft can be learned.

The difficulty is not to write, but to know what you mean, and to affect your reader, but to affect him precisely as you wish."

Consider this passage:

"It is now time for us to get to work, to become involved as individuals in any way we can. It is necessary to bring the armies up to establishment, and also achieve victory in the air. Mine sweeping and construction of ships must be combined. The utilization of guards and first aid personnel should be increased. We must all work together because time is short."

The meaning is clear enough. How did the passage affect you? Not much? But as Churchill spoke it he not only affected his audience but he affected them precisely as he wished.

"Come then: let us to the task, to the battle, to the toil—each to our part, each to our station. Fill the armies, rule the air, pour out the munitions, strangle the U-boats, sweep the mines, plough the land, build the ships, guard the sirels, succour the wounded, uplift the downcast, and honour the brave. Let us go forward together in all parts of the Empire, in all parts of the island. There is not a week, nor a day, nor an hour to lose."

The craft is obvious. Every statement is positive. Among some two dozen nouns, all but four are concrete. The verbs are strong, vivid and in the active voice. Churchill used two types of parallel construction in the first sentence, one is the second, one is the third and one in the fourth. His style is consistent, sentences 1, 3 and 4 progress from the large and the general to the small, the particular, the individual.

Nowhere is the craft more important than in the communication between doctor and patient.

"Your disease can only be alleviated by an operation." Is the doctor saying "Only an operation can alleviate your disease; no other treatment will do"? Or is he saying "an operation can only alleviate your disease—an operation cannot cure it?"

What a difference the location of one four-letter word makes to the patient.

Nowhere is the craft more important than in the communication between doctor and patient. The blend of logic, clarity and precision with gesture, tone, and inflection is the essence of communication.

U of T Medical School

## CONCERT BAND

Rehersals: Mondays 7 PM, Alumni Lounge  
All Musicians (Good & not So Good) Welcome  
(Instrument Rental Subsidized)  
Corine Dierenfeld musical director 924-5300







## Open House

FEBRUARY 22-23 was Open-House weekend at the Medical Sciences Building. Despite unforeseen difficulties with the publicity, an estimated 1000 visitors turned up to see displays, films and videotapes on the Cardiovascular and Nervous System.

The busiest items on the ground floor were the EGG and Heart Sounds demonstrations and, in a nearby room, Dr. George Watts who discussed almost every aspect of the brain and its function, and interpreted EEGs being generated in the same lab by assorted alpha-freaks.

For the first time ever, the Anatomy Museum was opened to the public and proved—not unexpectedly—to be the most popular exhibit of all.

This Open-House was conceived by Mike Lawrie, planned by an appointed committee of staff and students, supported by the Dean and the Medical Society, and set up and manned by a throng of volunteers. To all those who helped, in whatever way, I would like to express my heartfelt thanks: Ron Cyr, Chairman, Open-House Committee.

Photos, clockwise: John Marshall, shown here with twice as many brains as he's ever had, explains the intricacies of the limbic system; Hoffi Schlosser attentively studies an ARF display, perplexed visitor listens as Sue Fawcett clarifies the action of the heart valves, while Jim Gibson discusses on heart murmurs generated by a cardiophonosimulator.



## G. Peeing: How Can You Miss?

By MURRAY TRELOAR

THE PEOPLE of Ontario are unhappy. More than half the people say there are not enough doctors in their communities, and specifically, almost two-thirds of the people feel that there are not enough general practitioners.

Furthermore, 80% of the people are unhappy about the service they receive. They say their doctor is unwilling to make house calls, that he is unavailable when needed, that he doesn't keep appointments on time and then does not give them enough time in the office.

However, there is one reality Ontario physicians possess—competence. He may be aloof, uncommunicative and too busy, but few people complain of incompetence. (Pickering Report p. 15-1).

The consumers of medical care in Ontario, our future patients, have presented many complaints about the existing system and its participants. One significant problem, from which many of the foregoing complaints stem, is that there are too few primary care physicians to go around.

A desire to help people, despite the woe words of this phrase, is still perhaps the best expression of why you and I entered medicine. The choice of a lifetime in general practice might well satisfy this altruistic feature of our personalities better than any other medical career. And the satisfactions which could accompany this one are legion.

Sheer bliss

Suppose you entered general practice. Suppose a good friend joined you and together you established a group. Furthermore, suppose you located in a medium-sized Ontario community—a community so in need of doctors that the local Lions' Club offered to build a new clinic for your group. A community situated fifteen minutes from skiing in winter and swimming or boating in summer.

You and your family could live there free of commuting, city noise and polluted air. The people of the community would receive needed medical care. They would be happy. You would be happy. The People of Ontario would be happy—ah, bliss!

Are you going to become a general practitioner? I would like to digress here and smooth down some of my readers' hackles. The foregoing picture of adequate medical services was derived by survey of 778 Ontario homes in 1972. The survey was conducted for the OMA by the retired group under the direction of Edward Pickering, a retired industrialist, and the results were published in April of 1973.

It should be clear that objective evidence of a physician shortage is not being reported; rather it is the feelings of those Ontario residents who were surveyed that are quoted. And the consumer discontent articulated in the Pickering Report is only part of this atmosphere. A second

component is the reward factor.

The blissful view I have given of small-town medical practice is not imaginary. I invite you to read in detail about general practice in Port Dover, a community of 3902 people on Lake Erie, in the Canadian Medical Association Journal, Sept. 1, 1973, page 420.

Framing the case

I have used information from these reports in an attempt to materialize the atmosphere I feel surrounds us as "Ontario doctors-to-be".

Are you going to become a general practitioner?

Some of the parameters you might wish to keep in mind while framing your case include: Location of Practice: Urban or rural; near university hospitals for up-dating your knowledge; near arts and recreation facilities for maintaining your soul.

Remuneration: Group practice is increasingly popular, both for GPs and for specialists, so that you may not be your own boss initially. In this situation, there are many ways to slice the cake, some better than others. In general, a GP is more likely to be salaried (about \$1500 per month initially for a 60-hour week) than is the specialist.

Hours of Practice and Coverage System: Ditto above.

Scope of Practice: When do you refer? As a GP member of a group which includes both generalists and specialists, you may find a lot of pressure to refer cases early to

your specialist partners. Secondly, what diseases bring people to the GP?

Continuing Education: What (lectures, peer review, journal clubs) and more importantly, when? This is a greater problem for the GP than for the specialist as a rule. The specialist is kept up to date by constant hospital contact, whereas the GP frequently must set time aside for study.

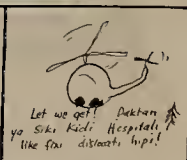
Paramedical Personnel: The GP is relying increasingly on his nursing staff in all phases of medical care (diagnosis, treatment and follow-up). Not so the specialist. What are your personal feelings about managing two nurses and a receptionist?

Office Contact. Here you might muse on the cost of running an office, efficient record and appointment systems and architecture of an office and/or clinic.

Community Resources: Old age homes, acute and chronic care facilities, visiting nurses, social workers, physiotherapists, diagnostic labs and so on, can be a great aid to the GP (family physician). Does the practice location you have in mind offer these services?

Taking some of these factors into consideration, the Pickering Report came out with a profile of the GP.

The primary physician is generally regarded as



working long and indeed excessive hours, cutting seriously into family life and alone social and community life and even interfering with the upgrading of his professional training and skills' (Pickering Report p. 46).

This is an exceedingly brief outline. It is supposed to whet your appetite for further discussion. So let's proceed to look at some sources of information about general (family) practice. With these in arm you will perhaps make a reasonably self-satisfying case for or against general practice.

Reading around it

The Pickering Report, being up-to-date, is a good place to begin. What you do is telephone the OMA, identify yourself as a medical student and request a copy of the report PLUS the "statistical papers" which complement it.

There you can find what the public thinks of its doctor and what he thinks of himself, his income and costs, his attitudes and background, and his hours and conditions of work.

(see Reading, page 8)





# PERIPHERAL CIRCULATION

By MARSHALL KORENBLOM

THERE IS, apparently, a high probability that this Faculty will have to expand to over 300 students within the next five years. There is therefore a high probability as well that increased use of peripheral hospitals will have to be considered in order to accommodate the extra D.I.T.'s (Doctors-in-Training).

In view of these facts, I thought it would be worthwhile to clarify some of the advantages and disadvantages of such a move, based on my own experiences at two such hospitals: one for Neurology in IIA, the other for Musculo-Skeletal System in IIC.

Let me state at the outset, that I favour such a change. I will present both good and bad points, but I definitely think that the experience would be valuable, if it were to come about.

The "cons", as I see them, are as follows:

- Simply getting there. Some of the peripheral hospitals are quite peripheral, to say the least. This is no small disadvantage in terms of money spent and time lost for just travelling. The inconvenience factor is undeniably high, especially if the majority of one's lunch hour is consumed by getting from the MSB to the hospital.

- Since ties with downtown are stretched very far, communication is often compromised and this can result in uncertainty, by the clinicians, as to what is "core" material, or what is "supposed to be covered". This conceivably could put peripheral students at a comparative disadvantage with their downtown comrades, come exam time.

- Patient distribution can be quite different, due to the make-up of the surrounding community and due to the existing trend of sending patients downtown to see the "super specialists" if the disease is particularly complex or unusual. Consequently, the exposure to disease processes may differ substantially.

- As an extension of the above point, since much of the interest in unusual or florid-and-not-so-unusual disease is downtown, peripheral students might not get a chance to see "first-hand" the men or machinery involved in the latest advances.

The "pros" are as follows:

- The very fact that the peripheral hospital (henceforth referred to as "P.H.") is removed from downtown means a freer hand in curricula changes and teaching methods. Less structure, centralization and bureaucracy can mean less conformity and constraining standardization, and more freedom.

In recent experience, the clinicians asked us, "Well, what would you like to look at or discuss today?" I find that this approach is less "learning for the exam" and more "learning for learning's sake", certainly a welcome change.

The different patient distribution can also be an advantage in a number of ways. First, it has been my experience that the patients are, on the average, younger than in the downtown hospitals (henceforth, referred to as "D.H."). Therefore, one sees disease processes earlier and becomes adept at recognizing earlier signs. This increases one's diagnostic acumen and provides more of an opportunity to see preventive medicine being practised. Second, since many of the "canaries" are downtown, one's perspective changes from looking for the rare to looking for and seeing the common. In this sense, I believe that the P.H. is more in touch with the "real" world of medicine than the D.H., whose patient selections are "skewed" to the rare entities and are, hence, artificial to some extent. At the same time, (thirdly) one sees some syndromes that would not be seen downtown (e.g., those related to farming or agricultural occupations).



- As an extension of the above, the P.H. is more "generalist" than "specialist" oriented. By this I don't just mean that the G.P. plays a larger role in the hospital (although this is true, especially in the Emergency Dept.) but also that specialists at P.H. do a lot of general medicine and don't confine themselves to their fields as seems to be true downtown. (e.g., an orthopedist grabbed us to take a look at a cellulitis even though it was not on our musculo-skeletal "schedule" or in his particular field.)

- In spite of the concentration of research funds and activity in the D.H. most of the P.H. are much newer buildings and, therefore, have newer "standard" equipment and even newer "new" equipment. Thus, although the D.H. may be able to conduct sophisticated investigations to further knowledge in the less-common or presently puzzling areas, the P.H. has newer or better developed machinery to deal with the common practice of medicine as it is today, (e.g., a new X-ray technique which shows soft tissue better than ordinary radiographic methods).

- Following the above, the newer architecture is a benefit both esthetically and functionally. The abundant colour and shiny newness of the buildings is a lift to both doctor and patient.

Some new structural and spatial concepts are being used at the P.H. (e.g., designing the Emergency Dept. with the examining rooms in the periphery of a "box" instead of down elongated halls and the equipment and charts in the centre of the box, facilitating quick progression from room to room and locating essential materials within easy reach of the doctor; having smaller, decentralized nurses' stations and more of them, in order to be closer to the patient's rooms instead of one huge complex at one end of the floor; using newer air-filtration systems which constantly recycle the air in patients' rooms, in order to achieve lower concentrations of contaminants in the air).

- In the P.H. one finds that the patients have not been "used" before and are, therefore, not sick of students coming to examine them.

- Similarly, the eagerness of the clinicians, who are neither tired nor bored of teaching students, makes for an engaging, lively time which is interestingly divided between making rounds, didactic discussion, some lab exposure, X-ray interpretations, and Emergency Dept. work, all interspersed with a coffee break during which the clinician usually discusses something of topical or personal



interest, not necessarily related to the "core" material.

- There is no competition for "good cases": the entire hospital patient load is available without hassle.

In sum, I think P.H. has a lot to offer students, both in and of itself, and by comparison to the D.H. I think it merits serious consideration by the powers-that-be and support from us, as one way of accommodating more students in the class without allowing the quality of our education to suffer.

The "Suburban General" ain't so bad, after all.





### Magical Medical History Tour (Instalment II)

In 1890, the faculty and students of the Women's Medical College (established in 1883) moved into their brand new building at 291 Sumach Street, opposite the old Toronto General Hospital. The value of the lot and buildings was reported as \$12,000.

Over the next 16 years 120 physicians were graduated from the women's Medical College to become medical missionaries and women's doctors. The dissolution of the college was brought out by the acceptance of women into the newly reorganized faculty of medicine at the University of Toronto in 1906.

The Women's Medical College building still stands. For any M.D. who wants to make the pilgrimage, it's just north of Gerrard on Sumach and now houses the Avery Machine Company.

The old TGH is gone, of course. It moved into its new building on College Street in 1913.

## Reading while G. Peeing

(from page 5)

More recent income data is provided in the December 15th issue of the CMAJ in an article titled "Medical Economics: MD Incomes 1961-1971".

The U of T Medical Journal, in the February 1968 issue, considered general practice as a career. The editorial writer was Or R.L. Perkin, a 1954 Toronto graduate currently the Professor and Coordinator of the Residency and Coordinator of the Residency Training Program in Family and Community Medicine at this university.

In his editorial he discussed in specific terms the features of general practice, family practice and specialist practice. The articles in this issue of the journal were also specific in their discussions of general practice. The article by W.J. Prost (678), "The GP - The Man and his Ethics" was exemplary in this regard. The character of the GP, the scope of the GP and the small-town GP are all discussed.

In the April 1969 edition of the same journal Mel Iscove (679) reviewed his summer experience as a preceptor in the TGH General Practice Clinic. His analysis of what problems the GP sees in office practice is novel and enlightening.

In Dr. Iscove's opinion 70% of initial complaints are diagnosed at the first visit as functional, and this diagnosis is confirmed by further investigations. Ten per cent of complaints are misdiagnosed as functional at the initial visit, and investigations reveal organic disease. Conversely 10% of complaints are misdiagnosed as organic and prove to be functional. The final 10% of cases are diagnosed and confirmed as organic illness.

Finally in the same journal, November 1971 edition, L.S. Erick (771) reviewed the "How-to" of organizing a general practice. A detailed analysis of

the cost of maintaining a practice is also given (about \$24,000 per annum at that time).

There are very few textbooks about general practice. It is fortunate that the most recent book (1971) is well written. It is The Modern Family Doctor and Changing Medical Practice, by J.P. Geyman. Chapter titles in this book include: Towards a New Health Care System, The Family Doctor's Office, The Family Physician's Bag and The Nature of Family Practice, to name only those I found most interesting.

#### Office visits

By comparison with Dr. Iscove's analysis of what the scope of presenting complaints is in general practice, I offer the following analysis from Dr. Geyman's book.

Among office visits, 22% are for acute respiratory illness, 10% for trauma, 6% for gastrointestinal problems and 5% for psychiatric problems. Gynecological, dermatological, cardiovascular, eye and ear problems, and sacralgia, physical examination, allergies, superficial skin infections and minor surgery each contribute 4% or less. Of all these problems, about 4% result in hospitalization. It was unclear from Dr. Geyman's statistics what portion of each of these complaints had a significant functional component.

If you have observed that our medical educators are almost exclusively specialists, and have wondered at this curious fact, I refer you to the Scientific American, September 1973. There, "The Medical School" by R.H. Ebert gives a historical view of the problem, if it is a problem. Furthermore, Charles Redden has published many articles in the Canadian Family Physician, the official journal of the College of Family Physicians. These articles have been well-written discussions about establishing practice or joining a group, and

about managing a practice.

Aside from the text by Geyman already mentioned, there is a dearth of information about these aspects of being a family physician. In fact one of the chief recommendations of the Pickering Report was that the CMA establish a service for physicians which would advise them on office management. So I expect that the forthcoming text by Mr. Redden (to be published April 1974 by Longmans Canada Ltd) will be good reading for anyone contemplating family medicine.

You can play an amusing and informative game while reading "The Vanishing Practitioner" by E.B. Harvey J.G. Med. Educ. 48: 718-724 Aug. 1973. This article reports the results of a study of Ontario physicians which compared 109 who had always been in general practice with 7 who left for specialist practice.

The game one plays while reading this article consists of matching up personalities: your own with each of the groups studied. When this is completed, you gaze intently into the mirror and predict that you will or will not become a GP.

#### Preceptorships

An informative experience open to those of you who are in Meds I or II is the Ontario Government Summer Preceptorship Program. The details of this program are available in the Student Affairs Office.

I participated in this program last summer and intensely dislike for you to give a well. Many of my classmates also took part and loved their experience. Thus it is unlikely that you will find the experience boring or uninteresting.

In addition to advising you to participate in the program if possible, I would offer one other item of advice. Talk to the directors of the program and attempt to divide your summer in two, spending one half with GP "X" and one half with GP "Y".

You can also contact your family GP in Toronto, if you have one, and ask to spend your elective afternoons in his office. This is a last winter and very much enjoyed the experience.

One final recommendation is that you subscribe to the Canadian Family Physician. For five dollars per year you receive a well written monthly magazine. Many of the articles in this journal are written by and for GPs. As such, they help to fill the gap between specialist medicine taught at the university and practical medicine used in the community at large. You can telephone the College of Family Physicians at 499-9430.

**LAST MINUTE BULLETIN:** The College's Summer Patterns is bringing out a guide to practice management, called Manual on Family Practice.

Now in the hands of the printers, the manual should be available for distribution within several weeks. It is designed to provide medical students, residents, teachers and practicing family physicians with a practical reference to such essential matters as the family practice office — location, design and layout; office equipment, clinical records and billing procedures; administrative, legal and accounting arrangements in family practice; the family practice office staff; the family practice office as a community health center; public and professional relations in a family physician's office; and other matters concerning the day to day management of a busy family practice.

## Ticket To Ride: The GP, FP, or FRCSC Line?

By KEN SIREN

LICENSURE is of late becoming a hot topic in medical cocktail conversation, spawning rumours the realization of which could have a rather significant effect on the future directions of practice of today's medical students.

At present, graduates of Ontario medical schools are granted a license to practise upon successful completion of the LNCC exams and a one year internship of any type in an approved hospital. Beginning this July, the practical requirement becomes more precisely defined as an approved clinical clerkship plus a one-year postgraduate internship, either rotating, mixed or straight. Acceptable straight internships are those in Medicine, Surgery, Obs. & Gyn., Paediatrics or Family Medicine. Mixed internships must comprise forty or more weeks in two or more of the above services, and rotating internships must include six or more weeks in each of Medicine, Surgery, Obs. & Gyn., Paediatrics and Psychiatry.

All this and a pinch full of quarters gives one the right to practice medicine, but the opportunities for practice in the future are now being discussed by many people involved in health care, both professional and political, and some of the proposals being made may directly influence the decisions we must all too soon make regarding our professional directions.

Recently the provincial health ministers announced that they may consider a plan to set regional quotas on the number of practitioners in a given field who can bill either directly or indirectly through the government health insurance system. Although this plan is not a certainty, it should be taken under advisement by those who are seriously considering a heavily populated branch of medicine and who place a high priority on location of practice.

Even that lone wolf of medicine, the general practitioner, may be affected by this evolution. A committee of the College of Family Physicians of Canada has put a proposal to the licensing authorities suggesting that College

certification be the minimum qualification for full licensure. Doctors without this certification by the CFPC are granted upon completion of a comprehensive examination (which has a 20 per cent failure rate) following either a two year residency or a five year period of clinical independent practice and approved postgraduate course work. This latter route will be terminated in 1980 and thus only applies to those who graduate in 1974. The college requires regular course work (100 hours every two years) to maintain certification.

This licensure proposal of the CFPC committee will be considered for adoption as official policy by the College executive in the near future. Regardless of the decision they make, demand for family practice residents will surely continue to increase based on its past growth rate and the phasing out of the practice eligibility route. As the CFPC stipulates that a rotating internship is not acceptable as the first year of a family practice residency, one's decision to obtain certification must be made during the clerkship year. The residencies are only available in teaching hospitals which are rapidly reaching their capacity to accept them, and applications may soon outstrip the places available.

The certified family practitioner will surely hold an advantage over his non-certified colleague with respect to desirability by patients, obtaining hospital admitting privileges, scope of practice, and financial return should licensure regulations change.

This is not to suggest the medical community will wake up within the next few days to find its legal terms of practice altered. Current license holders have a rather large say in the setting of regulations, and no one is going to cut off his nose to spite his face.

The present discussions and proposals do however reflect the broadening scope and basis of medical practice and the impossibility of mastering it all. A longer period of formal training and an earlier decision on the part of the medical student regarding his field of practice may be one way of making sure that both the patient and the physician feel the physician is competent.



# A Profile of Today's Medical Student

The following article by Dr. Michael M. Myketyk (a family physician) and Dr. James E. Miles (an assistant professor of psychiatry at UBC) originally appeared in *CMAJ Journal*, December 1, 1973, Vol. 109 and has been reprinted with the kind permission of the authors and the CMAJ. The original includes a bibliography.

"He was always and carefully dull; smilingly, easily, dependably dull. If there was any cliché which he did not use, it was because he had not heard it yet. He believed in the Episcopal Church — but not the High Church; he believed in the Constitution, Darwinism, systematic exercise in the gymnasium, and the genius of the President of the University."

This stereotype of a boring conventionalized yet by Sinclair Lewis to depict Irving Waters, a typical medical student, is no longer applicable to today's Canadian student-physician. He is a different breed of individual rising to meet the challenge of a changing medical scene. This paper will attempt to provide a profile of the current medical student with comments on the motivations, background, personality and attitudes which bring to medicine and how these parameters are affected by the present-day medical educational system.

The University of British Columbia Medical School accepts approximately 60 new students each year. The average age of freshman in 1970 was 21.5 years, and 21.7 years in 1971. The usual ratio of male to female students has been four to one but in 1971 women formed approximately one third of the first-year class. Whereas 20 years ago internships were not readily granted to married medical graduates, the trend today is to marry while in medical school. In the 1972 University of British Columbia graduating class of 64 students, 41 were married compared with 17 married students entering medical school. The majority of the marriages occurred during the second year. Furthermore, at the same university an average of 20 per cent of first-year medical students have either an undergraduate or postgraduate degree.

Prospective medical students frequently articulate deep concerns with the physical, emotional, social and cultural problems of people expressing these concerns in operational terms. "The medical applicant perceives sets of problems and desires to serve as an instrument in their alleviation or correction. He is prepared to approach human problems from a very broad base in which social, environmental, cultural, economic and political factors figure more prominently than the exact molecular bases of disease and illness. The student

understands his eventual role to be that of an individual physician dealing with individual patients. He does not see himself as leading teams or dealing with population groups. Little does he know that from the broadly oriented, humanistically inclined yet relatively uncritical student, he will somehow become the critical, analytical, logical and scientifically oriented physician.

The compellia for medical school entrance is far keener than for any other graduate or professional education. This makes it imperative that the premedical student maintain the high grade-point average that is so enthusiastically listed after the screening committees. The medical student's personality must be strong enough to cope with the stresses of the student-physician metamorphosis. The majority of students respond to this very competitive situation with work of extra-ordinarily high quality. In order to achieve these grades the premedical student must maintain adequate amounts of control, thoroughness and self-discipline. He puts intellectual matters above emotions, security above pleasure, service to others above self-service (at least at conscious levels), and exactitude above fantasy. He is the student who works harder for good grades than most. He puts intellectual matters above emotions, security even in the subjects he dislikes. He is rigid and perfectionistic,

nicely categorizing himself under the obsessive-compulsive personality type which comprises over 60 per cent of medical students. "This type of student is attracted to medical school since it is a way of gaining control over life and death, serving others, and satisfying his intellectual needs". Furthermore, besides getting good marks, he makes a favourable impression on the medical school admissions committee, often composed of people with similar personalities.

The obsessive-compulsive student finds an easier time of it in medicine than in any other faculty; there is a fit between the structure and organization of the traditional school, the demands placed on the students by the school, and the obsessive student himself, to the extent that these characteristics become even more prominent as the student goes through school. The school rewards and reinforces the very traits already described. Some of the more progressive medical educators, recognizing this reinforcement of "undesirable" traits, have tried to de-emphasize the grade consciousness and to stress the importance of learning as preparation for future practice. Theoretically, this approach would be expected to alleviate the anxiety of the students. For some students it does, but for the obsessive-compulsive this

approach can backfire. "These students find it necessary to prove themselves and need the high grades and rank as a defence against the anxiety of insecurity and vulnerability."

Like the cloistered monk, the medical student leads a very constricted and dependent existence. Usually the young adult recognizes his basic tasks of occupational identification and the growth of a capacity for intimate relationships with others. The medical student is no exception to this rule. However, the student-physician is too pre-occupied with the task of becoming a doctor, not only in acquiring the knowledge and skills of the doctor, but also in more subjective attributes, the inner feeling of becoming and then being a doctor, the certainty that the role fits him and that society approves and accepts his newly acquired role behaviour. Learning to identify with the professional role involves not only attending classes, clinics and the laboratory, but interacting with his peers, instructors and his patients. The intensity and concentration of this process of the student to construct his range of interests and outside pursuits within the sequestered medical environment. Much of outside living escapes the medical student's "winning state". The doctor's long and arduous training does nothing to qualify him in

psychology and does much to disqualify him. It keeps him so busy from 18 to 25 he finds he has little-aged before he has the leisure time in which to discover himself.

The medical student has more difficulty establishing autonomy from his parents, and he usually finds it harder than other students to make friends with classmates since they must relate in a competitive way. He must postpone the developmental tasks of late adolescence until later on in medical school when his deferred problems become pressing at a time when the academic and other demands on him are at their peak. This postponement results in further anxiety for the already insecure medical student.

By now it should be obvious that the medical student does not fit the stereotype of the average "hip" college student who is free with love, money, drugs and sex. Furthermore, he does not fit the popular fantasy of the carefree, blundering but successful student doctor as seen in the British comedy "Doctor in the House" or the American film "The Interns". He does, however, emulate the public's image of the "good old family doctor" who in turn is the embodiment of the Hippocratic Oath.

(See Profile, page 11)

## Living with Licensure

By LOUISE SIMS

THE COMPLEXITIES of licensure procedures, and the inner workings of the College of Physicians and Surgeons of Ontario, were explained at a seminar held in the MSB on February 9. Dr. J. Dawson, Registrar of the Ontario College, and Dr. W. Paul, chairman of its Medical Review Committee, conducted the discussion as part of the Ontario Medical Students Weekend.

To the lowly undergraduate student, who can barely see past his anatomy reassessment, or the Period II Comprehensive, the maze of bureaucratic institutions which will regulate his future practice is distant and confusing. The structure, for the benefit of the totally uninitiated, is as follows.

Licenses are granted at the provincial level. The Ontario College of Physicians is the licensing body as designated by the Medical Act of Ontario. Its council consists of elected members as well as representatives of the medical schools and the Minister of Health. It serves "to protect the public and to preserve the civil rights of physicians."

It does not determine medical school curriculum (although Faculties of Medicine often discuss major changes with the college before instituting them). Nor does it conduct its own licensing examinations. These are administered by the Medical Council of Canada, a federal body with representatives from each provincial College, and the LMCC's are accepted by every province as part of licensure requirements.

Neither of the above institutions is to be confused with the Royal College of Physicians and Surgeons, a federal body which grants limited specialty practice. The Ontario Medical Association, a voluntary association of Ontario physicians practising in all fields, or the Ontario College of Family Physicians, which does not grant licenses, but issues certificates in family practice.

Licensure, as defined by Dr. Dawson, is the "act of identifying to the public those who by education and training are qualified to provide services." The requirements for licensure in Ontario are LMCC registration plus one year of internship, which as of July 1974, will have to be a rotating, mixed, or straight internship in one of Surgery, Medicine, Pediatrics, Obstetrics and Gynaecology, or Family Practice.

This excludes, for example, straight internships in Psychiatry or Laboratory Medicine. A graduate of one of these programmes, who decides to go into general practice, must complete the minimum requirements in the other essential fields before obtaining his license (which can, apparently, be accomplished in 6 months).

Most provinces accept the same licensing standards, exceptions, including Alberta which will soon require year internship, and Nova Scotia which accepts rotating internship.

Many students at the seminar expressed concern over the role of the Ontario College of Family Physicians, which, in a recent position paper, recommended that completion of the two-year family practice residency become the basic

requirement for licensure. But we were assured that the OCFP is not a licensing body, and the CPSO, at present, has no plans for increasing its licensure requirements. As Dr. Paul put it, "There is no evidence that the requirements for a practicing physician who are incompetent or below the level of public interest." One year of internship combined with the clinical clerkship, "if it is serving its proper function", said Dr. Dawson, "should be adequate".

At present the licensing body doesn't inspect the clerkship programmes, but this is "probably coming."

It was stated that the internship residency is a "good programme", and the certificate in family practice may be considered as a "stamp of excellence in family practice but there is doubt as to whether the 2 years are necessary for the protection of the public." Thus, it was said, the residency programme is probably "optimal", but not minimal preparation for practice. On the other hand, hospitals, universities, and other bodies can set their own hiring standards beyond the license to practise, and it may be that possession of the minimal prerequisites for licensure will not guarantee the staff position of one's choice.

The Complaints and Discipline Committees of the CPSO also serve the role of "protecting the public." Any person may question the "personal conduct of a physician, or the quality of his practice," and petition the Complaints Committee, which conducts an investigation. If there is evidence of misconduct, the Discipline Committee questions the physician, and determining the penalty, which may range from reprimand to license suspension (for up to 1 year) to erasure. (A physician erased from the Register may apply for reinstatement after a given period.)

Other functions of the CPSO include inspection of intern training programmes, and examination of complaints regarding quality of hospital practice.

As well, the Medical Review Committee assesses the quality of practice of individual physicians. Screening is conducted through OHP records, and doctors whose billings exceed a level predetermined by peer committees of the various specialties are selected. The billings reveal the volume of practice, and the quota is felt to represent the level above which the "corners of quality of practice might be cut." In defending such a system, Dr. Paul assured us that no doctor's billings are rejected until his practice has been thoroughly inspected by another physician. The OHP records, then, serve only as a screen.

And it is expected that under the new Medical Act, the College will have the authority to inspect any physician's records and practice, regardless of OHP records. Dr. Dawson stated that before that happens, it is hoped that the OMA and the CPSO will warn doctors and provide educational material inducing them to keep proper office records. "Records kept by physicians," he said, "usually bear no resemblance to the histories that medical students are taught to take."



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# You Win A Few, You Lose A Few...



Bill Cashey (24) takes a shot while Ron Sternberg (43) watches. Meds came from behind in this close one to beat Vic. 1 by a score of 72-70.



In the last minute Meds lost this waterpolo game 4-3 to Vic. Both were undefeated as they came to the match.

By PETER PETROSONIAK  
THE HIGHLIGHT of the athletic season up to this point has been the recent Medical Student Week of Feb. 9. Athletics constituted a large portion of the events of the weekend and the Meds teams fared very well in the competition, although the turnout from U. of T. Meds Students at Hart House was a little disappointing.

The Meds "A" basketball team demolished the squad from University of Ottawa and also a combined team of medmen from Queen's and Western Ontario. The U. of T. Meds volleyball team beat both Queen's and Western Ontario in the two games it played.

In the evening hockey games at Upper Canada College's Patrick Johnson Arena the incomplete U. of T. team encountered difficulty typing U. of Ottawa 4-4 and then lost 3-0 to a strong U. of Western Ontario team. However, the Toronto Meds men came back in the second round of play to beat a combined squad of Ottawa and Western Ontario doctors 7-3. The M.A.A. is indebted to the Medical Society for their coordination of the weekend.

In intramural sports, since the last issue of Auricle, the seasons have ended in touch football, squash and volleyball. The Dodgers, a third year team in the touch football league, won the championship by beating Innis in a best-of-three final. The squash squads did not fare too well, but the volleyball team made the playoffs only to lose out in the first round.

The Meds "A" hockey team has won some big games so far this year but are still struggling to make the playoffs. The regular season in the intermediate league

is now nearing the end and Meds "B" promise to be a strong contender in the playoffs.

After a somewhat slow start, the Meds "A" basketball team is now challenging Victoria and St. Mike's Colleges for basketball supremacy.

The water polo team is, at this point, undefeated, but it has yet to play its toughest game. Meds again placed second in the winter

swim meet with 107½ points, 35 behind Victoria College, the Fitzgerald Trophy winners.

In the spring time Medicine is in the lead by approximately 30 points in competition for the F.A. Reed Trophy, recognizing participation and excellence in intramural sports. The final standings will depend on how the water polo, basketball and hockey teams fare.



Champion Meds I basketball team includes (from left, back row): Whiteside, Lustvey, Hanna, Motz, Hrycystyn, Lynn, Grant, Lynn, Missing, Glichrst.

## Basketball Champs

By HELEN LYNN  
WE'RE glad to report the Meds I Women's basketball team have had an undefeated season and are the 1973 interfaculty champions.

The final game against Erindale was played by both players and cheering fans. Leading scorer was Hazel Lynn (22 points) and highest jumper was Louise Hanna (6 ft. 7). Others scoring for Meds were Grant (4), Whiteside (2), Hanna (1).

Ron Motz did an excellent job coaching and photographing throughout the season. The team greatly appreciated his work and concern (the even wore pressed blue jeans to the final game).

Congratulations to Louise Hanna who won a silver medal for high jumping at the British Commonwealth Games in New Zealand. She jumped 5 feet 11¼ inches.

## Profile Of A Medical Student

(from page 8)

enter I will go into them for the benefit of the sick and will abstain from every voluntary act of mischief and corruption; and further from the seduction of females or slaves, be they freemen or slaves."

Hippocrates mentions abstaining from the "seduction of females", but how much does the average medical student know about the "seduction of females"? As already mentioned, one of the young adult's tasks is to strive for a capacity to achieve intimate relationships, especially with the opposite sex. The relative isolation from the outside world, the attempts to model his behaviour on the image of the "good doctor", and his basic personality pattern in which a degree of emotional isolation has been present anyway, not only interfere with sexual

experimentation but likewise interfere with the development of intimacy with his friends and empathy with his patients. "The exchange of feelings, the sharing of goals and values, of attitudes and beliefs with a loved person, is inhibited unless there is time for meeting potential mates and developing such relationships."

One would think that the medical school curriculum would include some explanations of human sexuality. What does the medical student learn about sex? He learns the names and functions of the organs of procreation, but is not given any clue as to what constitutes "normal" human sexual behaviour. It is rather sobering to imagine the influences on the patients of a physician who, over a professional lifetime, believes that masturbation causes insanity, or that oral stimulation between marital partners represents perversion.

"Furthermore, many medical students themselves are concerned with problems of potency, masturbatory anxiety and fears of latent homosexuality. These problems are all related to the obsessive-compulsive personality structure. The solidification of one's identity as a competent heterosexual male is a task of adolescence and adolescence is frequently extended beyond the usual years in the case of students. The competitive demands of their premedical and medical studies interfere considerably with the time normally available to adolescents and young adults for the social and sexual experiences that solidify one's self-concept as an adequate male."

There is an increasing number of medical students meeting their sexual frustrations by marrying while still in medical school. However, although many sexual conflicts are resolved by marriage, the marriage itself is grossly affected by the omnipresent medical educational system. Since the student has very little time to devote to his wife and children, he is torn between his desire to play with his family and his compulsive need to study. The conflict produces guilt and irritability which tax the marriage bond and lead to passive-aggressive behaviour. Furthermore, the wives find themselves having to adjust to the loneliness, irregular hours, marginal finances and husbands who are under constant tension and pressure. "For the most part, the medical students' wives find their roles challenging, interesting and meaningful and do not wish that their husbands were in a different profession. A few, however, have needed psychiatric help to make the adjustment."

The medical school functions as a "colossal castrator" for the unwary student. The self-image of the well-controlled obsessive-compulsive medical student is progressively and permanently attacked by the "educational"

program. The nature of medical education is such as continually to place the student in circumstances where he feels inadequate as compared to other men (senior students, house staff and faculty) around him. The vastness of the material learned, the lack of cues, as to what should be left out, the first confrontation with the cadaver, the first breast or pelvic examination, and the first exposure to the seductive psychiatric patient make the medical student even more insecure in himself. What is most frustrating is the feeling of powerlessness to do anything about changing the setup. All these events can be shattering to the student's self-esteem, and the need to calm such feelings can lead to numerous defensive positions which may cripple the student's interpersonal effectiveness with his patients, family and friends.

Another stress faced by the medical students is the conflict between what they expect from medical school and what they get. When the bright-eyed, enthusiastic but frightened first year student enters medical school he is secretly afraid he won't make it but cautiously confident that he will. The mystique of the medical school is strong and from the beginning there are disappointments — poor lectures, inadequate and repetitive material, fragmentation of subjects and the general lack of coordination which the freshman thought he left behind in high school and college. He begins to study only for examinations, bypassing his fields of interest as

he tries to assimilate the vast amounts of jumbled material. However, buried in the cluttered, anxious thoughts of his mind and encouraged by the faculty is the engram that he as a student does not have the competence and must trust the system, hoping that all the pieces will eventually fall together.

A further conflict facing medical students is the one between physicians in academic medicine and those in the community. While faculty members press them on to specialized or academic careers, practitioners encourage them to enter general practice. This divergent counselling poses a soul-searching problem for the medical student whose career choice is based on admiration for his family doctor.

Financing a medical education is a costly process. The climbing costs of fees, books and accommodation are ever present on the student's mind. The expense in itself is not so frustrating as the poor returns he receives by way of faculty time and interest. As the students see that not only are they not receiving full value for the funds expended in their education but they are being asked to subsidize the teaching hospital with their labour and time. The only way a student can gain attention or recognition by a faculty member is by becoming a special interest in that person's specialty. The student responds to his exploitation by "fighting the system" — student activist, by employing passive resistance and emotionally coping out of the

(see Profile, page 12)

**The Period One Teachers Squash Racquets Association Challenges**

A team from Meds I or Meds II or Meds III or Meds IV

or Meds II III III IV

to a round-robin match (all play one game with all to let elderly recover between games).

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# Profile Of A Medical Student

(from page 11)

system (sleeping in, cutting labs, late completion of assignments) or by joining the system. "The great interest aroused by this situation has a damaging effect on interpersonal relations with faculty members and administrators and ultimately interferes with learning and personal development."

In Canada, women constituted 14% of medical students in 1969, a 50% increase since 1965. They face the same stresses as the men and more. The medical school is still a male world and a relatively inhospitable one for a woman. The environment is dead serious, highly competitive and extremely tense. Consequently, the egocentric male students, many with financial and domestic responsibilities, show little consideration for their classmates, particularly the women. The female students have to cope with this brusque attitude in some way. "A few women assume a more masculine role, hoping this will open the door to the male world. Other women will seek identity by becoming super-termites. One popular way to gain entry and acceptance in the male world is by marriage to another medical student. The women medical students in addition face the problems of controlling the timing and size of their families. This latter problem is more acute in the clerkship year where night duty is mandatory."

There are certain familiar ways that students handle the stresses and frustrations of medical school. Some of the methods have been mentioned already in

connection with the married and women students. Generally speaking, the commonest mechanisms used are humour, denial and many forms of regression. Humour, for example, is often used to break the tensions of examinations or the discussions of sexual matters. Denial and repression are constantly being used by the student in order that he may study with a "clear mind". "Repression takes the forms of suppression of conflictual material, isolation of disturbing subjects, repression of aggressive affect, repression of tender affects, and repression of growth and creativity". Another ego defence mechanism commonly used and very familiar to the obsessive-compulsive student is the obsessive-compulsive. He produces productivity and achievement. He

literally "loses" himself in work. "Other less frequently used defense mechanisms include fantasy retreat, introjection, hostile assertiveness and negativism".

Another well-recognized stress response in medical students is hypochondriasis or somatization of their anxieties. This phenomenon occurs in practically every medical student, intern or resident at some time in his career, but is particularly common during the study of pathology in second year. The student may feel a "lump in his throat", experience "pain in the chest" or during his psychiatry rotation think he is a "latent homosexual". Most students react with an attempt to allay their

anxiety through intensive study of the disease in question by direct or covert consultation with instructors. "Despite the humour usually surrounding the subject of 'medical students' disease', the student may be experiencing general emotional turmoil, and it may represent a cry for help by the student who is fearful of exposing his need and desire for psychiatric consultation".

The complex system of defences used by the medical student to protect his ego from anxiety remains with him and colours his outlook on life, at least until he reaches internship. He builds up a cynicism concerning medical school and medicine in general compounded by a massive repression of affect. He is hard to

approach on a personal level. He is suspicious of and uncomfortable with, psychiatric patients. He describes a "good patient" as one who can produce a clear-cut, rational history accompanied by definite physical signs in the shortest period of time. This insensitive human computer is quite different from the naive but refreshing premedical student mentioned earlier, who expressed deep concern with the "physical, emotional, social and cultural problems of people". It is not until the last few months of medical school when the end is clearly in sight that the medical student begins to lower his defences and indulge in more humanitarian attitudes. Unfortunately for some, the die is cast in medical school, giving rise to the superficial matter-of-fact "Doctor of Medicine" who it is to be hoped will find a haven away from people, in such fields as pathology, laboratory medicine or biochemistry.

Today's medical students are complex individuals. Some run the medical school gauntlet and escape relatively unscathed while an increasing number are expressing their discontent with the "system" and are "acting out". Although the advent of medical school activism is more prominent in the United States, its presence is now being felt at the University of British Columbia over such issues as time spent in laboratories and the financing of the clinical clerkship program. The image of the modern-day medical student, therefore, is still undergoing a rapid change in order to meet and perhaps shape the role of the future physician.

## Not Enough Clinicians

(from page 1)

are purely ephemeral, and more and more pressure comes to bear on the students and the present teaching staff and hospitals.

Who is making the decisions? Who is representing the students and the teaching staff at these negotiations? Why aren't there enough clinicians to maintain a decent clinic group size?

Who reassures the government that U. of T. medical school can accommodate 70 more students per class without having the unpleasant job of trying to fit these people into an already overloaded system? Why is expansion being considered at all

if, as the government predicted in a front page article in the Globe & Mail (Feb. 15, 1974), we are facing a surplus of doctors?

The progressive, insidious increase in the size of clinic groups is seen by many as a dangerous precedent, for there is more at stake than the fact the groups are too unwieldy for productive interaction and patient student clinician contact. Without continued pressure and objection to these tactics, the illusion is reinforced that the present structure can accommodate increases—and they will continue.

Neither clinician nor student

can afford, for the sake of education of anything but assembly-line physicians, to quietly allow expansion to go on around us, a little every year, if it compromises the quality of our education and overtaxes the existing resources at the hospitals.

The somewhat flexible mass teaching of Period I must be carried over into Period II; the hospitals cannot accommodate the numbers which the medical building perhaps can. If the medical class is to continue to grow, then the capacity of the entire faculty to take on this extra load must keep pace.

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